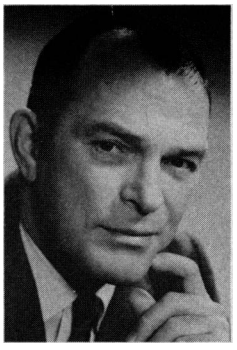

Dr. J. D. Wallace, CMA Secretary-General

Loneliness and a feeling of rejection are common to every geriatric institution

Society in general, and medical science in particular, has done much in the past fifty years to extend the life span of the average North American. This combined with the early age of retirement enforced by many industries has been in many ways beneficial to those concerned and to their families. However it has in turn created a whole series of problems. In spite of considerable expenditures of public funds over the years and the development of better facilities for the provision of social and health services for this growing segment in our population, we have not as yet been all that successful in solving those problems. For many of our senior citizens the time after retirement is not the golden age that it is cracked up to be.

Many of you have undoubtedly visited senior citizens lodges, nursing homes, old boarding houses and chronic care institutions in which senior citizens are congregated together to spend what they call their declining years. In many parts of the country citizen groups with support from municipal and provincial governments and often financial support from federal sources have built modern and comfortable facilities for both healthy and not so healthy older people. In other areas they are crowded into older but still comfortable facilities. However for far too many, particularly those alone in the later years of life, the supposedly golden end of life's rainbow is a dingy room in a crowded old folks home or run down hotel. In all of these accommodations from the best to the worst, there are two underlying characteristics in common — loneliness and a feeling of rejection. Even the best organized social programs in the newest lodges and minimum care institutions never quite dispel these basic feelings. For a variety of psychological and sociological reasons, these feelings appear more marked in men than in women.

The North American scene was selected as an example because here we have a combination of factors that exaggerates the problems. We enjoy life on the most affluent and supposedly advanced continent on earth. To maintain and perhaps further elevate these factors our work ethic is dedicated to action, production and operational efficiency, and to an increasing degree to personal financial and status achievement. Those considered too old, or too free from pressure and the stress syndrome, to compete in our "rat race" are cast aside, often in good health and with many more productive years left to them. Unless they have developed hobbies, or, wisely, some little business endeavours to manage themselves, they suddenly are on their own with nothing to do. The funds carefully set aside for "old age" and the pension plan returns are usually inadequate to meet the costs of living in our inflated economy let alone the financing of those trips planned but never taken.

By comparison with older societies in the world we have a relatively weak respect for family ties and obligations. As an urbanized culture with a high expectation rate for quality rather than quantity in living accommodations, we do not normally make provision for the care of aging parents or grandparents. We are content to let "the community" take care of that. We believe we have fulfilled our obligation by providing some of the bucks required to finance the care. To this we add having the old folks over for a romp with the grandchildren and a family meal on Sunday. It's no wonder that many of our previously healthy senior citizens are plagued by an increasing variety of real and imaginary health problems.

At this point in time our health services, like our society as a whole, are primarily geared to action — get patients into the system in a hurry, cure them and turn them loose until the next interesting acute episode occurs. Most of the newer health care facilities have been developed on that basis, and the vast majority of the health workers are educated and trained with that priority in mind. They get bored with the inaction involved in the care of long term patients, and acute care facilities just aren't organized to handle convalescent cases effectively.

Any major change in our North American way of life is unlikely in the foreseeable future. We should therefore recognize the crisis we face in geriatric care. Because of a dearth of health workers motivated to, and educated in, the proper care of geriatric problems, there is little hope we can cope. It is a curious thing that we have over the years developed a highly specialized core of expertise and knowledge in the care of children and have at the same time virtually ignored the other end of life's rainbow.

As our noted past-president, Dr. Gustave Gingras — internationally renowned expert in rehabilitation and geriatrics — said in his first presidential address: "Geriatrics is at present the ugly duckling in the health field. I intend to do something about it. After all I'll be a potential geriatric patient in ten years and I want the system to be much better prepared then, than it is now, to look after me." Next time you have an opportunity to visit a facility catering to the needs of the "old folks" give the geriatric problem some serious thought. Perhaps it is still not too late for organized medicine to assist in at least partially remedying the situation by publicly recognizing the problem, providing a leadership role in its solution and granting appropriate recognition and status to the doctors and other health workers who specialize in geriatric care — at least that's the way I see it . . .